

Submission template

Response to *Review of the Mental Health Act 1986 Consultation paper*

Introduction

This template is designed to assist people in making a submission in response to the *Review of the Mental Health Act 1986 Consultation paper*. It contains a list of the questions posed in the consultation paper. Comment is welcome on any matter related to the Act, and need not be limited to the questions in the paper or the *Some key questions* paper.

Please note: Closing date for submissions is 5:00pm on Friday 27 February 2009. The use of this template is optional.

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List of questions in *Review of the Mental Health Act 1986 Consultation paper*

Chapter 2 questions: Background and framework for reform

Q1. What, if any, additional reform objectives should be reflected in the new Act?

The discussion paper leaves me with an impression that any new legislation might only slightly less narrow in focus than the current Act. The discussion paper fails to put forward a vision for a piece of modern legislation that recognises changes in the way that people might have their illness treated and where consumers and carers will get information from. Many of the ideas and questions in the document continue to focus around issues associated with acute treatment and care and the current relationships between the service provider and the service user. The attention given to the role and the opportunity of the "carer" is token.

Q2. What principles, departmental objectives and functions should the new Act include?

A modern Act would promote Empowerment in every situation possible.

A modern Act would promote the involvement of another nominated party in a support role in every situation possible.

A modern Act would promote the priority for treatment to be carried out in community settings where possible. Where treatment in an acute setting was necessary discharge would take place when the appropriate community support arrangements had been put into place.

A modern Act would provide for a nominated "carer" to have legal standing.

The Office of the Chief Psychiatrist would always be physically separated from the Mental Health agency and the Office would include a Community Advocate for MH who also would be a statutory appointee

Chapter 3 questions: Involuntary orders

Q3. How should mental illness be defined in the new Act?

Q4. What conditions should be excluded from the definition of mental illness in the new Act?

Q5. If separating the involuntary treatment process into three stages is supported:

(a) What should be the grounds for each order?

(b) What should be the duration of each order?

(c) Should there be any restrictions on the kinds of treatment that can be given under each order?

Q6. How should the new Act address the issue of a person's capacity to consent to treatment in the grounds for an involuntary order?

A key factor that is missing in this whole section is the recognition of a role for a nominated person (carer). This has not been explored in sufficient detail

Q7. How, if at all, should the new Act define what constitutes capacity to consent to treatment?

Q8. What requirements, if any, should the new Act contain for deciding whether or not a person has capacity to consent to treatment?

Q9. In what circumstances, if any, should the new Act permit a person to be placed on an involuntary order where the person has capacity to consent and is refusing treatment?

Such a situation should automatically trigger a second opinion being obtained.

Q10. How should the new Act address the issue of the seriousness and immediacy of risk in the grounds for an involuntary order as they apply to:

(a) The person?

(b) Others?

Q11. How should the new Act address the issue of 'immediate treatment' in the grounds for an involuntary order?

Q12. How should the new Act address the issue of the 'least restrictive manner' in the grounds for an involuntary order?

Q13. What requirements, if any, should the new Act contain to enable involuntary patients to provide informed consent to a wider range of psychiatric treatment?

Available treatments could be stratified - least "intrusive" to most intrusive -eg seclusion.

Q14. If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?

The agency should have to respond to any request from a consumer or nominated other party.

Q15. What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist should the new Act include?

In disputes, Chief Psychiatrist could have final decision.

Q16. Should the new Act include a best interests requirement in relation to treatment decisions made by the authorised psychiatrist?

The service should and should be seen to be always offering and exploring with the patient (and Carer) what options are available.

Q17. How should the new Act address the issue of children and young people who do not have capacity to consent to treatment due to their mental illness?

Q18. What requirements, if any, should the new Act contain for clinical reviews of involuntary patients subject to:

(a) An involuntary treatment order?

(b) A community treatment order?

Q19. In what circumstances, if any, should the authorised psychiatrist consent to the annual examination of an involuntary patient?

Q20. What obligations, if any, should the new Act impose in relation to reporting results of annual examinations?

Q21. If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?

Q22. What should be the duration of a community treatment order in the new Act?

Q23. Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?

This matter needs some attention in respect of a person who could be on a CTO, have private health cover and not be able to access treatment services from a private clinic. One situation that can occur is the person who is denied access to Day Programs being offered. The situation arises because in order to attend the Day Programs, the private health insurer requires that the person be "admitted". Because the Act operates to prevent a person on a treatment order being admitted to a private treatment facility, the patient cannot access the day programs! There may well be other examples that are relevant here.

Chapter 4 questions: Patient participation in treatment and care

Q24. What obligations, if any, should the new Act impose in relation to informing a patient's family, carer or nominated person of a patient's rights?

Act should recognise that modern forms of communication should also be available eg videos of TMS, ECT, videos of patient testimony etc

Q25. If a nominated person scheme is considered necessary, how should the new Act address this?

The new Act should give a nominated person Legal Standing so that it places an obligation on the service provider to keep the person informed and involved on a regular basis.

Q26. What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

Q27. What requirements, if any, should the new Act contain to assist voluntary patients to understand and exercise their rights?

The act should be linked to the new National MH standards for this area of information provision. It would be a responsibility of the suggested Community Advocate that monitor and report on these activities. As a minimum, information areas would have to include:

Rights and responsibilities

Complaints

Advance statement documents.

Treatment plans

Review schedules

Discharge plans

Carer information.

Q28. What requirements, if any, should the new Act contain to address issues of:
(a) Patient involvement in treatment planning?

Act needs to spell out the relationship between any service treatment plan and a GPs treatment plan

(b) The content of treatment plans?

Conformity with new national MH standards

Conduct of progress reviews in presence of consumer and carer and with communication sent to GP.

Q29. What additional requirements, if any, should the new Act contain to ensure the effectiveness of treatment plans?

As above

Q30. If an advance statement scheme is considered necessary:

(a) What requirements should the new Act contain to ensure their effectiveness?

Provision for voiding by the consumer.

Requirement for periodic review and re-confirmation say every 2-3 years.

(b) In what circumstances, if any, should the new Act allow an advance statement to be overridden?

Authority from the Chief Psychiatrist

Chapter 5 questions: Electroconvulsive therapy

Q31. How should the new Act regulate and monitor:

(a) Premises on which ECT is provided?

Requirement for licensing and inspection of premises should continue

(b) Persons who administer ECT?

Training requirements should remain in place

Q32. How should the new Act address the issue of a person's capacity to consent to ECT?

Q33. If oversight of consent to ECT is considered necessary, what type of scheme should the new Act contain?

Q34. How, if at all, should the new Act regulate provision of ECT in an emergency?

Discussion paper fails to establish the case of an emergency situation.

Q35. How should the new Act address patient participation where ECT is proposed?

Q36. What additional safeguards, if any, should the new Act contain where ECT is proposed for a young person?

Chapter 6 questions: Restraint and seclusion

Q37. How, if at all, should the new Act regulate physical restraint?

Before these question can be answered the discussion paper needs to indicate an awareness of decisions from the 2008/09 Forum(s) dealing with seclusion and constraint. Any recommendations from these activities would eventually go to AHMAC.

Q38. How should the new Act address the grounds for mechanical restraint and seclusion?

Q39. What obligations should the new Act impose on the authorised psychiatrist in relation to authorisation of mechanical restraint and seclusion?

Q40. What obligations should the new Act impose in relation to the clinical monitoring of secluded or mechanically restrained patients?

Q41. Should the new Act require mechanical restraint or seclusion to end 'immediately' when the grounds for their use are no longer met?

Q42. If regulation of physical restraint is considered necessary, should the new Act:

(a) Authorise persons to exercise these powers?

(b) If so, who should be so authorised?

Q43. If the physical restraint, mechanical restraint and seclusion of voluntary patients is considered necessary in the new Act:

(a) On what grounds?

(b) For what duration?

(c) Subject to what safeguards?

Q44. What additional safeguards should the new Act contain for the effective regulation of restraint and seclusion?

Chapter 7 questions: review and appeals

Q45. (a) How soon after the making of an involuntary order should the new Act require external review?

(b) How frequently thereafter should the new Act require external reviews of involuntary orders?

Q46. What type of external body, what kind of proceeding, and what powers should the new Act contain for:

(a) External review soon after the making of an involuntary order?

(b) Subsequent external reviews of involuntary orders?

Q47. How should the new Act address issues of patient participation in external review?

New Act should mandate a time interval (say 21 days) for notification of patient before the date set for the review.

Q48. How should the new Act address issues of participation by families, carers or nominated persons in external review?

As above and through a carer having legal standing.

Q49. How should the new Act address issues of participation by members of the treating team in external review?

Q50. Should the new Act incorporate the functions of the existing Psychosurgery Review Board within the functions of the external body that reviews involuntary orders?

Chapter 8 questions: Monitoring patient wellbeing

Q51. (a) What monitoring functions and powers should the new Act contain?

(b) What type of body would be most effective in performing these monitoring functions and powers?

Q52. If publishing of information obtained through monitoring functions is considered necessary:

(a) What publishing requirements should the new Act contain?

(b) In what other ways should the new Act require that information obtained through monitoring is used to improve patient wellbeing and achieve service improvement?

Q53. (a) What death review functions and powers should the new Act contain?

Provisions in a new Act should be linked to changes in the Corner's Act. The changes should mandate that in the event of the death of any person within 12

weeks of discharge from a psychiatric facility, the Coroner would conduct an inquest into the death.

(b) What type of body would be most effective in performing these death review functions and powers?

Coroners Office

Q54. If the establishment of a clinical leadership role is considered necessary, what functions should the clinical leader perform?

Q55. If giving legal force to clinical guidelines or codes of practice is considered necessary, what should be the implications of non-compliance?

Chapter 9 questions: Complaints

Q56. What requirements, if any, should the new Act contain in relation to local complaint systems?

Compliance with National MH standards and Equip criteria

Q57. (a) What complaints functions and powers should the new Act contain?

Compliance with national MH standards.

(b) What type of body would be most effective in performing these complaint functions and powers?

as above

Q58. What requirements, if any, should the new Act contain to support patients to make complaints?

as above

Q59. What requirements, if any, should the new Act contain to ensure that information learned from complaints is used to promote service improvement?

Review by the Community Advocate for MH.

Chapter 10 questions: Confidentiality and information sharing

Q60. In what circumstances should the new Act *permit* disclosure of information to families and carers without patient consent?

Issues of consent, privacy and disclosure are a real mess. My impression is that the Privacy legislation is probably technically problematic

Q61. What key events should the new Act *require* be disclosed to a patient's family, carer and any nominated person without patient consent?

Changes in a new act may not fix up problems if another Act is at fault.

Q62. In what additional circumstances, if any, should the new Act require disclosure of information to guardians?

Q63. In what circumstances, if any, should the new Act allow a guardian to consent to the disclosure of information about a patient?

Q64. (a) What service providers, if any, should receive identified information without a patient's consent?

(b) If so, in what circumstances should they receive identified information without a patient's consent?

Please attach any further comments.

The discussion paper has failed to consider a number of developments that are taking place.

These include websites that provide information and patient chat rooms about medications. Should these be regulated in any way?

Another significant development is the emergence of call centres that provide some type of triage and treatment advice. While these appear to be staffed by nurses and allied health professionals, the fact is that no patient is ever observed. Eventually misunderstandings and adverse events must occur. At the moment these call centres are linked to private health insurers although it is understood that the system is to be trialed within the public MH service in Western Australia.

Early intervention and proper psycho-social programs are other promising services that appear to have been over-looked in the discussion paper.

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